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ABSTRACT

Drawing on the work of Pruyser (1976) and Malony (1985, 1987), the Religious Status Interview (RSI), a measure of theological functioning, was created. The RSI was designed to help counselors judge the health of a parishioner's religious beliefs as they relate to the problem that brings the person to pastoral counseling. This study investigated the validity of the RSI using a sample of 45 Christians diagnosed with an addiction to food, drugs, or alcohol who were in a Twelve Step program. Researchers tested the concurrent validity of the RSI by testing to see if it could differentiate relapse-free time. The theoretical construct of the instrument, that theological functioning relates positively to psychological health and negatively to personality pathology, was also tested. Criterion variables were depression as measured by the Beck Depression Inventory (BDI)(A. Beck and R. Steer, 1987), self-concept as measured by the Tennessee Self-Concept Scale (TSCS) (G. Roid and W. Fitts, 1987) and personality pathology as measured by the Millon Clinical Multiaxial Inventory (MCMI) (T. Millon, 1987). Results indicate that the BDI and the TSCS are not good predictors of relapse-free time. Nor is the RSI alone. However, there is a significant interaction between the RSI and the self-satisfaction scale of the TSCS predicting relapse-free time. Contrary to expectation, the MCMI was not a better predictor of relapse-free time than the RSI. Data support the value of using a religious inventory like the RSI when counseling. (Contains 4 tables, 1 figure, and 13 references.) (SLD)

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Running head: A VALIDITY ESTIMATE OF THE RSI

A Validity Estimate of the Religious Status Interview

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Paper presented at the Annual Meeting of the American Psychological Association,

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A Validity Estimate of the Religious Status Interview

Statement of the Problem

According to Gallup polls released since 1952, the percentage of Americans who believe in God has hovered around 90 percent (Paloma & Gallup, 1993). Other surveys have determined that 20 percent of Americans claim to be Evangelical Christian believers. This amounts to 50 million Americans who refer to themselves as Bible-believing Christians (Balmer, 1989; Gallup & Jones, 1989).

These large numbers of Christian men and women fall into a variety of categories when it comes to problems of psychological health. Some Christians struggle with life-controlling problems such as addictions to food, alcohol, drugs, gambling or sex, while others have problems with depression, anxiety or other psychological illnesses. Many Christians turn to their ministers for counseling when they are dealing with a life-controlling problem in order to get a theological framework (Pruyser, 1976). The problem for the pastoral counselor then is how to assess their client.

Assessment is a specific task that can be either distinct from or part of therapy, but in either case is pivotal to establishing the proper therapeutic intervention. Maxmen and Ward (1995) define assessment as a time-limited, formal process whereby the counselor "collects clinical information from many sources in order to reach a diagnosis, to make a prognosis, to render a biopsychosocial formulation, and to determine treatment" (p.19). A key phrase in the definition is many sources, and the pastoral counselor plays a key role in gathering information from the religious source. Unfortunately, for those engaged in pastoral counseling, formal assessments of clients' religious status have never been defined.

Kilpatrick (1983) surmised the lack of precision in formal assessment for Christian clients was due to the influence of "pop" psychology. He believed psychology had seduced ministers and other pastoral counselors into believing a theological perspective on people's problems was a small, insignificant part of their experience in relation to the psychological assessment. As a result, pastoral counselors often exchanged their theological evaluations for a psychological one.

Pruyser (1976) sought to remedy this situation by designing a series of categories which could be used to assess religious status. Religious status is defined as the extent to which a person's religion is functioning to impact his life, including his or her motives, beliefs, and behaviors. Persons who embrace

a religious ideology and express it in inconsistent behaviors would be in need of pastoral counseling. The problem with Pruyser's questions was there was no way of evaluating which responses were considered appropriate or inappropriate. Malony (1985, 1987), recognized the value of Pruyser s contribution and created The Religious Status Interview (RSI), which he extracted from Pruyser's (1976) theoretical formulation. According to Malony (1993) the construct being measured is "theological functioning" Theological functioning can be defined as the expression of Christian faith, as it relates to motives and behaviors, and its effect on personality (Malony, 1993). The RSI was designed to help counselors judge the health of a parishioner's religious beliefs as they relate to the client's presenting problem (Malony, 1993). Malony (1985) believed his measure was capable of correlating positively with factors associated with psychological health and to correlate negatively with factors associated with psychological problems. The present study investigates the validity of the Religious Status Interview (RSI) using a sample group of Christians diagnosed with an addiction to food, drugs or alcohol and who were involved in a Twelve Step program related to their addiction.

Subjects

The subjects were 45 Christians who were diagnosed as having an addiction to food, drugs or alcohol and were attending a Twelve Step program related to their addiction. Subjects were selected from a group of Christian inpatients at a free-standing psychiatric hospital in Southwest Florida.

Procedure

The researchers tested concurrent validity of the RSI by testing to see if the RSI could differentiate relapse -free time. The theoretical construct of the instrument - that theological functioning relates positively to psychological health and negatively to personality pathology was also tested. Criterion variables were depression as measured by the Beck Depression Inventory (Beck& Steer, 1987), self-concept as measured by the Tennessee Self Concept Scale (Roid & Fitts, 1988) and personality pathology, measured by the Millon Clinical Multiaxial Inventory II (Millon,1987).

Both descriptive and inferential statistics were used. The basic inferential statistic was the F-test

run on the general linear model. Statistical procedures employed the least square solution model testing procedures in which models were built to reflect the research question of interest. (Cohen & Cohen, 1975; McNeil, Newman & Kelly, 1996; Pedazur, 1982). Also a power analysis was run for the most conservative model. Based on that model, power was at least .65 when df1 =1, alpha = .05 with an n=45 and effect size of (f2 = .15). Additional control for Type I error build up was employed (Newman & Fry, 1972).

Instrumentation

The Religious Status Interview (RSI). The RSI (Malony, 1985, 1987) is a set of thirty-three questions designed to measure how a Christian is functioning in their faith along eight dimensions. The eight dimensions include the following:

(1) awareness of God: the degree to which people experience a sense of awe and self as creature in relationship to God.

(2) acceptance of God's grace and steadfast love: the degree to which people understand and experience God's benevolence and unconditional love.

(3) being repentant and responsible: the degree to which people take responsibility for their own feelings and behavior.

(4) knowing God's leadership and direction: the degree to which people trust in, hope for, and live out God's direction in their lives.

(5) involvement in organized religion: the degree to which people are involved quantitatively, qualitatively, and motivationaly in the church.

(6) experiencing fellowship: the degree to which people relate to and have a sense of interpersonal identity.

(7) being ethical: the degree to which people are flexible, and committed to, the application of ethical principles in their daily living.

(8) affirming openness in faith: the degree to which people are tolerant and not prejudgemental, and are growing, elaborating, and being open to newness in their faith.

The questions are open-ended and scores range from 0 to 165. Higher scores are said to be indicative of

higher theological functioning and that the person s faith serves as a psychological benefit to their overall health and well-being.

Beck Depression Inventory (BDI). The BDI (Beck & Steer, 1987) is a self-report inventory measuring depressive symptoms. The BDI consists of 21 items each with three possible responses. It was designed to assess the severity of depression in psychologically diagnosed patients, but has been used extensively with more normal populations.

The Tennessee Self-Concept Scale (TSCS). The TSCS (Roid & Fitts, 1988) was developed to tap the multi-dimensional aspects of self-concept. The scale consists of 100 self descriptive statements which portray a snapshot of the "self". There are two versions of the TSCS - the Counseling form (Form C) and the Clinical and Research form (Form C&R). Form C provides a scoring of 14 subscales. The instrument is divided into three rows (Identity, Self-satisfaction, Behavior) which look at self -esteem from an internal frame of reference and five columns (Physical Self, Moral-Ethical Self, Personal Self, Family Self, Social Self) which look at self esteem from an external frame of reference. These scores are then used to produce a 3x5 matrix. The TSCS is self administered and takes approximately 10-20 minutes to complete.

The Millon Clinical Multiaxial Inventory (MCMI-II). The MCMI-II (Millon, 1987) is a 175 - item inventory that assesses individuals along 22 scales diagnosing both personality styles/disorders and clinical symptoms or syndromes.

Results

Frequency counts run on the data indicate the sample contained 30 female and 15 male subjects. The socioeconomic status ranged from 0 to over $100, 000, with a mode of 0 to $9,999. Relapse-free time ranged from 0 to 54 months with a median of 0 and a quartile deviation of 3. Four of the subjects were diagnosed with a combination eating disorder and chemical dependency problem, 13 were chemically dependent, 5 were diagnosed with major depression and 23 with eating disorders. The mean age was 40.93 with an sd of 13.89 years. Religious denomination was indicated as 32 protestants, 9 Catholics and 2 others. Two were not reported. Forty-one of the subjects were white, 3 black and 1 Hispanic. The mean educational level was 13.91 years with an sd of 3.02. Correlations run between the RSI and BDI, RSI and TSC were not significant, $p > .05$. Nor was there significance between the BDI and the MCMI-II.

However, there was a significant negative correlation between the BDI and the TSCS ($r = -.49$, $p = .0027$) and also negative correlations between the BDI and the TSCS subscales of identity, self-satisfaction, moral self, personal self, family self and social self (see table 1).

Table 1

BDI Correlations (N=35)

Variable	1	2	3	4	5	6	7	8
1 BDI	--	-.49*	-.50*	-.40	-.41	-.43	-.42	-.45
2 TSCS		--	.75*	.71*	.61*	.74*	.65*	.63*
3 identity (TSCS)			--	.35	.35	.65*	.60*	.61*
4 self-satisfaction (TSCS)				--	.65*	.59*	.38	.43
5 moral self (TSCS)					--	.55*	.24	.39
6 personal self (TSCS)						--	.35	.40
7 family self (TSCS)							--	.31
8 social self (TSCS)								--

Note. All correlations are rounded off to the nearest hundredth decimal point and are significant at the .05 level. BDI = Beck Depression Inventory, TSCS = Tennessee Self Concept Scale. Variables 3 through 8 are subscales of the TSCS. N for correlations between TSCS and its subscales was 45. *After a conservative correction for multiple comparisons, these figures were still significant at the .05 level, $p < .001$.

There was also a significant correlation of .32, p= .036 between the RSI and relapse-free time (see table 2).

Table 2

RSI Correlations (N=45)

Variable	1	2	3	4	5
1 RSI	--	.31	.35	-.29	.32
2 Selfsat (TSCS)		--	.38	-.29	
3 Family (TSCS)			--	-.51	.32
4 Passive aggressive(MCMI-II)				--	
5 Relapse free time					--

Note. All correlations are rounded off to the nearest hundredth decimal point and are significant at the .05 level. Correlations which were not significant were left blank. RSI = Religious Status Interview; TSCS = Tennessee Self-Concept Scale; MCMI-II = Millon Clinical Multiaxial Inventory. Variables 2 and 3 are subscales of the TSCS and variable 4 is a subscale of the MCMI-II. After a conservative correction for multiple comparisons, these figures were not significant at the .05 level. $p \leq .005$

In addition, there was a significant interaction between the RSI and the self-satisfaction scale of the TSCS predicting relapse-free time (see table 3).

Table 3

Interaction between the RSI and self-satisfaction scale of the TSCS predicting relapse free time

Model	R^2	df	F	p	S/NS
Full model: Relapse free time = (56.92)u + (- 6679) RSI + (-1.752) Selfsat + (.0210) RSIsel + E	3948	3/38	265	0002	S
Religious Status Interview (RSI)				0032	S
Self- satisfaction (Selfsat)				0011	S
RSI * Self- satisfaction (RSIsel)				0003	S
Test RSI sel = 0					
Restricted model: Relapse free time = (-14.69)u + (.1312) RSI + (.1686) Selfsat + E	1431				

Correlations were also run between the RSI, BDI, TSC and the Millon Clinical Multiaxial Inventory II. Our hypothesis that there would be a significant relationship between subscales of the MCMI-II and the RSI was partially supported. A significant negative relationship was found between the RSI and the passive aggressive scale of the MCMI-II (r=- 29, p= 05). There were no significant relationships between the BDI and the subscales of the MCMI-II. Correlations between the TSCS total score and the subscales of the MCMI-II showed several significant negative relationships (see table 4).

Table 4

TSCS Correlations (N=45)

Variable	1	2	3	4	5	6	7
1 TSCS	--	-.49*	-.57*	-.30	.37	-.50	-.54*
2 schizoid (MCMI-II)		--	.52*	-.08	--	.44*	--
3 avoidant (MCMI-II)			--	--	-.37	.87*	.57*
4 antisocial (MCMI-II)				--	-.51*	--	.72*
5 compulsive (MCMI-II)					--	-.42	-.56*
6 self-defeating (MCMI-II)						--	.67*
7 passive aggressive(MCMI-II)							--

Note. All correlations are rounded off to the nearest hundredth decimal point and are significant at the .05 level. TSCS = Tennessee Self-Concept Scale. MCMI-II = Millon Clinical Multiaxial Inventory II. Variables 2 through 8 are subscales of the MCMI-II. * After a conservative correction for multiple comparisons, these figures were still significant at the .05 level. $p \leq .0025$.

Conclusions

Data indicate the BDI and TSCS are not good predictors of relapse-free time, nor is the RSI alone. However, there was a significant interaction between the RSI and the self-satisfaction scale of the TSCS predicting relapse free time. Subjects who scored in the top one third on the RSI and showed an increase in relapse free time as self satisfaction increased. Subjects who scored in the bottom third of the RSI and did not seem to profit from an increase in self satisfaction in helping them to stay relapse free. The

middle one third showed little increase in relapse free time when looking at the interaction between self-satisfaction and score on the RSI (see figure 1).

Our data supports the value of looking at a religious inventory such as the RSI when counseling. One would traditionally have expected the MMCI-II would have been a better predictor of relapse free time than the RSI. This was not the case. More importantly, our data suggests the importance of looking at both the RSI and the self satisfaction scale of the TSCS when considering the development of support systems for intervention purposes. Data suggests the religious component as well as building of self concept would be a better approach when working with those who have high RSI scores and life controlling problems.

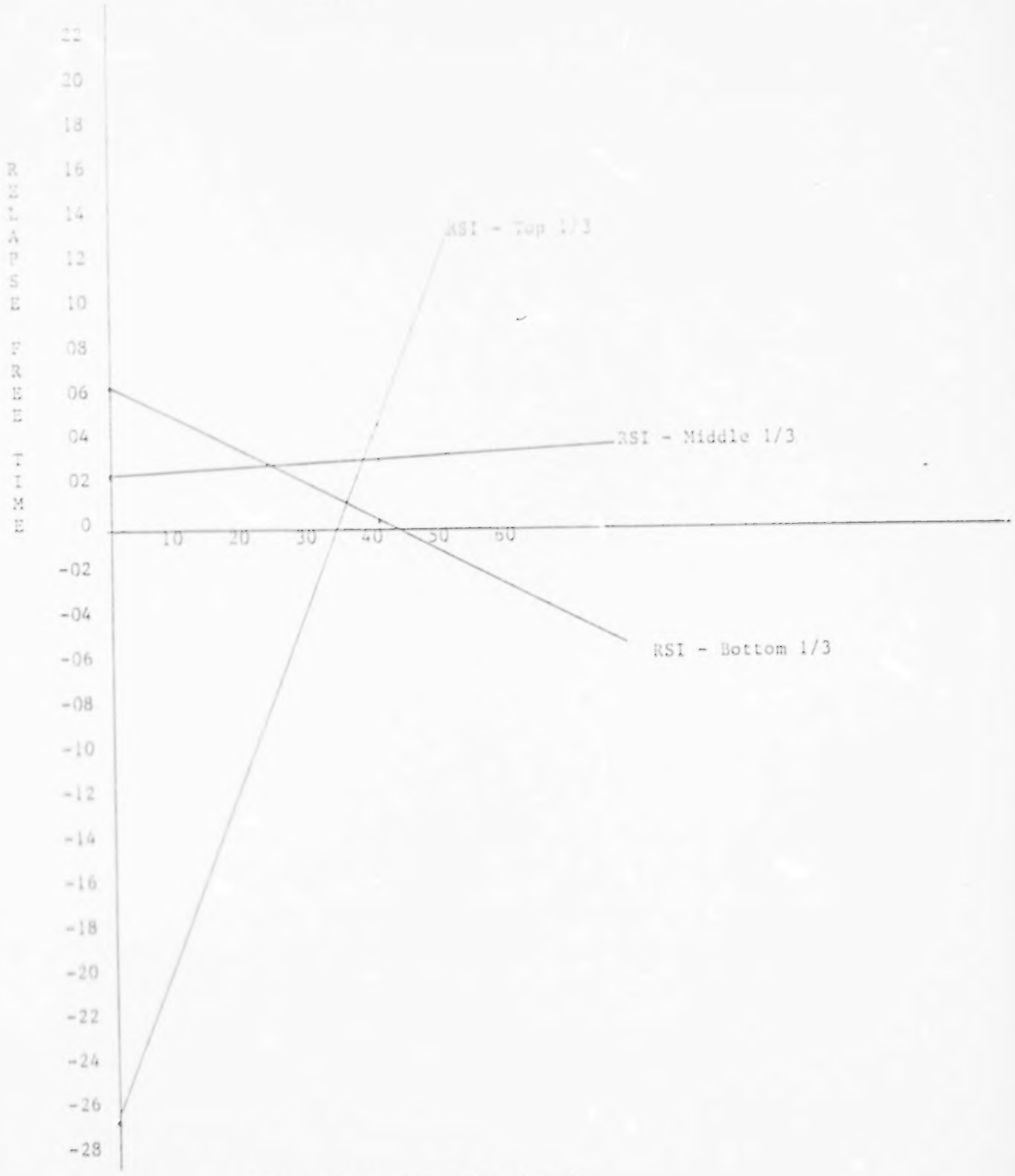
Most of the traditional therapeutic approaches attempt to build self esteem or increase self concept, but do so without looking at a religious perspective. Religious approaches often do not take into account the importance of building self esteem. Our data suggest combining the two approaches may produce better results than using either approach separately.

Serendiptously, we found a negative relationship between certain of the subscales of the TSCS and the MMCI-II. Although some of these relationships were hypothesized (and tested directionally) the emphasis of the study was on the RSI. This data also supports some of the constructs of the TSCS are negatively related to some of the constructs of the MMCI-II and depression as one would predict.

This would seem to be further support for what is being done in traditional therapy. That is, that by building up self concept, one may expect a decrease in maladaptive behaviors. A problem may be that depending on the theological position of a particular pastoral counselor, self esteem may be decreased instead of increased.

Like most research dealing with complex human behavior, there is no one simple answer, but a variety of variables to consider. The emphasis of this research was on the need to consider a religious perspective which can which has long been neglected in traditional counseling and psychotherapy.

Figure 1



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